EC-2

Rev July 2007

Hawaii Employer-Union Health Benefits Trust Fund
ENROLLMENT FORM FOR RETIREES

Customer Service Phone: 586-7390 or toll-free 1-800-295-0089

1. Event:

2. Event Date: (MM/DD/YY) _____/_____/_____

See Instructions on reverse side BEFORE completing this form. Refer to your benefits guide or our website for plan details.

3a. Last Name, First, M.I.	3b. Social Security Number (for new enrollees only) OR EUTF ID Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
3c. Mailing Address (❑ Check this box if your address has changed):	4. If your spouse or Domestic Partner is a State or County Employee or Retiree, please provide their SSN ___ ___ ___ / ___ ___ / ___ ___ ___ ___ If you are including your spouse or domestic partner in your health benefits plans, please complete sections 5 - 9.
3d. City: / 3e. State: / 3f. Zip Code:	
3g. Marital Status: ❑ Married ❑ Single / 3h. Gender: ❑ Male ❑ Female / 3i. Birth Date: (MM/DD/YY) / 3j. Phone Number – Home	

5a. Add	5b. Delete	6a. Dependents: First Name, M.I., Last Name (if different)	6b. Birth Date (MM/DD/YY)	6c. Social Security Number or EUTF ID Number	7. Relationship	8. Gender
❑	❑					M F
❑	❑					M F
❑	❑					M F
❑	❑					M F
❑	❑					M F

9. Plan Selections, Changes or Cancellations - Make your selection by checking the box for the appropriate benefit plans below. Select either Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan section.

Plan Section	*Carrier Selection*	*Current*	*Self*	*2-Party*	*Family*	*Cancel / Waive*
Medical Plan Select one plan from this list)	EUTF PPO Medical (HMSA Network, NMHC Drug)		❑	❑	❑	❑
	EUTF PPO Medical (HMA Network, NMHC Drug)		❑	❑	❑	
	Kaiser Comprehensive HMO and Drug		❑	❑	❑	
Dental Plan	HDS Dental		❑	❑	❑	❑
Vision Plan	VSP Vision		❑	❑	❑	❑
Life Insurance Plan	Standard Life Insurance		❑		❑	

10. Comments:

11. Certification (see instructions on back of this form)

Employee Signature: _____ **Date:** _____

12. MEDICARE PART B ENROLLMENT: Chapter 87A-23(4), HRS requires eligible beneficiaries "to enroll in Medicare Part B as a condition of receiving contributions and participating in benefits plans." If you or your dependents recently enrolled in Medicare Part B, please complete below and submit proof of your enrollment.
:

Name of enrollee:_____ Medicare Claim #:_____

(If you are completing this section, submit a copy of your Medicare card)

Submit to the EUTF via fax, 808-586-2161 OR,
Mail to EUTF, P.O. Box 2121, Honolulu HI 96813

INSTRUCTIONS FOR COMPLETING EC-2 FORM

A. Print or type clearly, if form is unreadable it may be sent back to you.

B. **Please submit form to the EUTF via mail to P.O. Box 2121, Honolulu, HI 96805; or by FAX to 808-586*-2161; or deliver to 201 Merchant Street, Suite 1520, Honolulu, Hawaii.**

C. **This form revised July 2007 is to be used for effective dates beginning July 1, 2007 or later. You may use this form for events that occur prior to July 1, 2007.**

D. Sections:

1. Event – Please enter the event. For example, Open Enrollment, Birth, Marriage, Divorce, Loss Coverage, Termination, Address Change, Retirement, Death, Change in Student Status, Add Dependent, Cancel, Surviving Spouse, etc.
2. Event Date – Please enter the date the event took place.
3. Enter Employee's information. For 3b, enter the EUTF ID #. For a new enrollee or surviving spouse, social security number (SSN) is required.
4. Enter SSN of Spouse or Domestic Partner if they are a State or County Employee or Retiree. In addition, complete sections 5 - 9, if enrolling spouse or domestic partner in any of your health benefit plans.
5. Check add box to add dependent, check delete box to delete dependent.
6. Enter Employee's Dependent(s) data. If enrolling for the first time, enter birth date and social security number. Otherwise, enter the dependent's age and leave item 6c blank.
   If listing more than 5 dependents, write "Continued" on the last line of the Dependent section. Use a separate letter size of paper to list additional dependent(s) information.
7. Use the following codes for Relationship column:
   SP = Spouse **CH** = Child **DC** = Disabled Child√√
   DP = Domestic Partner√ **DPC** = Domestic Partner Child√
   For Relationship codes with √ or√√, please see item #17 below for other required forms.
8. Gender – circle either M or F.
9. Plan Selections (See the Open Enrollment Guide for Retirees for plan coverage summaries). Select one plan from the Medical plans. Select the appropriate coverage for you. If you do not want any medical plan coverage, mark the "Cancel/Waive" box.
10. Comments – use this section for your comments. If additional space is required, please attach a separate letter size of paper.
11. **Certification:** Your signature certifies: 1) That the information provided in this application is true and complete; 2) That you agree to abide by the terms and conditions of the benefit plans selected. 3) That you affirm that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student.

IMPORTANT: When you attain age 65, you must enroll in Medicare Part B and forward a proof of your enrollment to the EUTF. Failure to comply may result in loss of all health benefits coverage.

12. If you or your dependents have recently enrolled with Medicare Part B, please complete this section and submit the form and a copy of your Medicare card or the letter notifying you of your enrollment in Medicare Part B to the EUTF.
13. **If you are an appointed representative and sign for the retiree, please ensure you have submitted documentation appointing you as a representative. If not, please submit the documentation with this form.**
14. Other EUTF forms to include with EC-2 (if applicable):
    √Domestic Partnership Declaration or Termination
    √ DHRD Domestic Partner PCP Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
    √Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
    √√D-1 (5/2003) for enrolling disabled child